

The Senate Committee on Finance offered the following substitute to HB 540:

**A BILL TO BE ENTITLED
AN ACT**

1 To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to
2 add to the list of tax categories eligible for an offset by the housing tax credit; to establish
3 standards for insurers and health care providers with regard to payment under a health benefit
4 plan in the provision of emergency medical services; to provide for applicability; to provide
5 for definitions; to provide for certain patient or prospective patient disclosures; to provide
6 for insurer disclosures; to provide for requirements regarding the provision of emergency
7 medical services for covered persons under a health benefit plan; to provide for requirements
8 for health benefit plan contracts between insurers and covered persons; to provide for
9 payments to providers; to provide for penalties for violations; to provide for mediation; to
10 provide for related matters; to provide for a short title; to provide for effective dates and
11 applicability; to repeal conflicting laws; and for other purposes.

12 **BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:**

13 **SECTION 1.**

14 Section 3 of this Act shall be known and may be cited as the "Consumer Coverage and
15 Protection for Out-of-Network Medical Care Act."

16 **SECTION 2.**

17 Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by
18 revising paragraph (1) of subsection (b) of Code Section 33-1-18, relating to housing tax
19 credit for qualified projects and rules and regulations, as follows:

20 "(b)(1) A tax credit against the taxes imposed under Code Sections 33-5-31, 33-8-4, and
21 33-40-5, to be termed the Georgia housing tax credit, shall be allowed with respect to
22 each qualified Georgia project placed in service after January 1, 2001. A Georgia
23 housing tax credit shall also be allowed against the taxes imposed under Code
24 Section 33-3-26 with respect to each qualified Georgia project placed in service after
25 January 1, 2020. The amount of such credit shall, when combined with the total amount

26 of credit authorized under Code Section 48-7-29.6, in no event exceed an amount equal
27 to the federal housing tax credit allowed with respect to such qualified Georgia project."

28 **SECTION 3.**

29 Said title is further amended by adding a new chapter to read as follows:

30 **"CHAPTER 20E**

31 33-20E-1.

32 This chapter shall apply to all insurers providing a health benefit plan that pays for the
33 provision of medical services to covered persons.

34 33-20E-2.

35 As used in this chapter, the term:

36 (1) 'Balance bill' means the amount that a nonparticipating provider may charge a
37 covered person. Such amount charged shall equal the difference between the amount
38 paid by the insurer and the amount of the nonparticipating provider's bill charge but shall
39 not include any amount for coinsurance, copayments, or deductibles due from the covered
40 person.

41 (2) 'Covered person' means an individual who is covered under a health benefit plan.

42 (3) 'Emergency medical provider' means any physician licensed by the Georgia
43 Composite Medical Board who provides emergency medical services and any other
44 health care provider licensed in this state who renders emergency medical services.

45 (4) 'Emergency medical services' means those health care services that are provided for
46 a condition of recent onset and sufficient severity, including, but not limited to, severe
47 pain, that would lead a prudent layperson possessing an average knowledge of medicine
48 and health to believe that his or her condition, sickness, or injury is of such a nature that
49 failure to obtain immediate medical care could result in:

50 (A) Placing the patient's health in serious jeopardy;

51 (B) Serious impairment to bodily functions; or

52 (C) Serious dysfunction of any bodily organ or part.

53 (5) Reserved.

54 (6) 'Gould Factors' means the following factors:

55 (A) The provider's training, qualifications, and length of time in practice;

56 (B) The nature of the services provided;

57 (C) The fees usually charged by the provider;

58 (D) Prevailing provider rates charged in the general geographic area in which the
59 services were rendered;

60 (E) Other aspects of the economics of the medical provider's practice that are relevant;
61 and

62 (F) Any unusual circumstances in the case.

63 (7) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into,
64 offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse
65 any of the costs of health care services, but shall not apply to Chapter 9 of Title 34,
66 relating to workers' compensation.

67 (8) 'Health care provider' or 'provider' means any physician or other individual who is
68 licensed or otherwise authorized in this state to furnish emergency medical services.

69 (9) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
70 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
71 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
72 costs of health care services, including an accident and sickness insurance company, a
73 health maintenance organization, a health care plan, managed care plan, or any other
74 entity providing a health insurance plan, a health benefit plan, or health care services.

75 (10) 'Medical services' means the examination or treatment of persons for the prevention
76 of illness or the correction or treatment of any physical or mental condition resulting from
77 illness, injury, or other human physical problem and includes, but is not limited to:

78 (A) Hospital services which include the general and usual care, services, supplies, and
79 equipment furnished by hospitals;

80 (B) Medical services which include the general and usual care and services rendered
81 and administered by doctors of medicine, doctors of dental surgery, and doctors of
82 podiatry; and

83 (C) Other medical services which include appliances and supplies, nursing care by a
84 registered nurse; institutional services, including the general and usual care, services,
85 supplies, and equipment furnished by health care institutions and agencies or entities
86 other than hospitals; physiotherapy; ambulance services; drugs and medications;
87 therapeutic services and equipment, including oxygen and the rental of oxygen
88 equipment; hospital beds; iron lungs; orthopedic services and appliances, including
89 wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs
90 and eyes, and any other appliance, supply, or service related to health care.

91 (11) 'Minimum benefit standard' or 'MBS' means the usual and customary rate defined
92 as the 95th percentile of allowable benefits and the 80th percentile of charges averaged
93 together for a particular medical service performed by a health care provider in the same
94 or similar specialty and provided in the same geographic area. Both percentile of

95 allowable benefits and the percentile of charges shall be reported in a benchmarking data
96 base maintained by a nonprofit organization specified by the commissioner. The rate
97 shall be tied to 2018 rates and may be adjusted for inflation according to the Consumer
98 Price Index for medical care or another indicator as determined by the department
99 pursuant to rules and regulations promulgated by the Commissioner. The nonprofit
100 organization shall not be affiliated with or receive funding from a health insurance
101 company and shall be accessible to providers without charge.

102 (12) 'Nonparticipating provider' means a health care provider who has not entered into
103 a direct contract with a health benefit plan for the delivery of medical services.

104 (13) 'Participating provider' means a health care provider who has entered into a direct
105 contract with an insurer for the delivery of medical services to covered persons under a
106 health benefit plan.

107 (14) 'Stabilized' means the effect of providing medical or surgical treatment for an
108 emergency condition as may be necessary to assure, within reasonable medical
109 probability, that no material deterioration of the condition is likely to result from or occur
110 during the transfer of the patient from a facility, or that with respect to a pregnant woman
111 who is having contractions, the woman has delivered the child and the placenta.

112 (15) 'Surprise bill' means a bill to a patient after medical services, not including
113 emergency medical services, where an unanticipated event results in the provision of
114 services by a nonparticipating provider.

115 (16) 'Usual and customary cost' means the charges routinely billed by the provider for
116 his or her professional services regardless of the payor involved and before any discounts
117 are applied pursuant to charity or financial assistance policies or insurer contracting
118 discounts.

119 33-20E-3.

120 (a) A health care provider who is a physician shall provide a patient or prospective patient
121 with the name or practice name, mailing address, and telephone number of any health care
122 provider that the office or surgery center utilizes for the provision of anesthesiology,
123 laboratory, pathology, radiology, or assistant surgeon services in connection with care to
124 be provided in the physician's office or an ambulatory surgery center owned by the
125 physician for the patient at least 48 hours prior to the provision of services where possible.
126 Such information may be provided by publication on the provider's website.

127 (b) Where an unanticipated event causes a change in the providers of radiology,
128 anesthesiology, pathology, or other services, the physician shall be held harmless for any
129 resulting bills from such provider or providers.

130 (c) A hospital shall establish, update, and make public through posting on the hospital's
131 website, to the extent required by federal guidelines, a list of the hospital's standard charges
132 for items and services provided by the hospital, including for diagnosis related groups
133 established under Section 1886(d)(4) of the federal Social Security Act.

134 (d) A hospital shall post on the hospital's website:

135 (1) The health benefit plans with which the hospital has an executed provider agreement;
136 (2) A statement that physician services provided in the hospital may not be included in
137 the hospital's charges, that physicians who provide services in the hospital may or may
138 not participate with the same health benefit plans as the hospital, and that the prospective
139 patient should check with the physician arranging for the hospital services to determine
140 the health benefit plans in which the physician participates; and
141 (3) As applicable, the name, mailing address, and telephone number of the physician
142 groups with which the hospital has contracted to provide services, including
143 anesthesiology, pathology, and radiology, and instructions on how to contact these groups
144 to determine the health benefit plan participation of the physicians in such groups.

145 (e) In registration or admission materials provided in advance of medical services, not
146 including emergency medical services, a hospital shall:

147 (1) Advise the patient or prospective patient to check with the physician arranging the
148 hospital services to determine:

149 (A) The name or practice name, mailing address, and telephone number of any other
150 physician whose services will be arranged for by the physician; and
151 (B) Whether the services of physicians who are employed or contracted by the hospital
152 to provide services, including anesthesiology, pathology, and radiology, are reasonably
153 anticipated to be provided to the patient; and

154 (2) Provide patients or prospective patients with information on how to timely determine
155 the health benefit plans in which the physicians participate who are reasonably
156 anticipated to provide services to the patient at the hospital, as determined by the
157 physician arranging the patient's hospital services, and who are employees of the hospital
158 or contracted by the hospital to provide services, including anesthesiology, pathology,
159 and radiology.

160 (f) Unknown or unanticipated services are not subject to the requirements of this Code
161 section.

162 33-20E-4.

163 (a) An insurer shall provide to a covered person:

164 (1) Information that a covered person may obtain a referral to a health care provider
165 outside of the insurer's network or panel when the insurer does not have a health care

166 provider who is geographically accessible to the covered person and who has appropriate
167 training and experience in the network or panel to meet the particular health care needs
168 of the covered person and the procedure by which the covered person can obtain such
169 referral;

170 (2) Notice that the covered person shall have direct access to primary and preventive
171 obstetric and gynecologic services, including annual examinations, care resulting from
172 such annual examinations, and treatment of acute gynecologic conditions, or for any care
173 related to a pregnancy, from a qualified provider of such services of her choice from
174 within the plan;

175 (3) All appropriate mailing addresses and telephone numbers to be utilized by covered
176 persons seeking information or authorization;

177 (4) An accurate provider directory as required by Chapter 20C of this title;

178 (5) Where applicable, a description of the method by which a covered person may submit
179 a claim for health care services;

180 (6) With respect to out-of-network coverage:

181 (A) A clear description of the methodology used by the insurer to determine
182 reimbursement for out-of-network health care services;

183 (B) The amount that the insurer will reimburse under the methodology for
184 out-of-network health care services set forth as a percentage of the usual and customary
185 cost for out-of-network health care services;

186 (C) Examples of anticipated out-of-pocket costs for frequently billed out-of-network
187 health care services; and

188 (D) Notice that the patient may be responsible for the balance of the nonparticipating
189 provider's fee if the rate paid by the plan is below the provider's usual and customary
190 amount;

191 (7) Information in writing and through an Internet website that reasonably permits a
192 covered person or prospective covered person to estimate the anticipated out-of-pocket
193 costs for out-of-network health care services in a geographical area or ZIP Code based
194 upon the difference between the amount that the insurer will reimburse for
195 out-of-network health care services, the patient's MBS, and the usual and customary cost
196 for out-of-network health care services;

197 (8) The written application procedures and minimum qualification requirements for
198 health care providers to be considered by the insurer; and

199 (9) Other information as required by the Commissioner.

200 (b) An insurer shall furnish an explanation of benefits to a nonparticipating provider within
201 30 days of receiving a bill from the covered person or directly from the nonparticipating
202 provider. The explanation of benefits shall conspicuously indicate whether the health

203 benefit plan coverage for the patient is subject to the requirements of this chapter, or
204 otherwise preempted under 29 U.S.C. Section 1144(a) as a self-funded employee welfare
205 plan regulated under the federal Employee Retirement Income Security Act of 1974, 29
206 U.S.C. Section 1002(1).

207 (c) An insurer shall disclose whether a health care provider scheduled to provide a health
208 care service is a participating provider and, with respect to coverage of nonparticipating
209 provider services, disclose the approximate dollar amount that the insurer will pay for a
210 specific health care service from a nonparticipating provider. Insurers shall also inform a
211 covered person through such disclosure that such approximation shall not be binding on
212 the insurer and that the approximate dollar amount that the insurer shall pay for a specific
213 health care service from a nonparticipating provider may change.

214 (d) Where services have been precertified or preauthorized by an insurer, the insurer shall
215 guarantee coverage of such services at the rates payed to a participating provider regardless
216 of any changes of network status following the precertification or preauthorization.

217 (e) Where an insurer fails to adequately and correctly keep its directory pursuant to Code
218 Section 33-20C-2 and such failure results in the unanticipated provision of out-of-network
219 services, the insurer shall compensate the provider at the provider's usual and customary
220 cost or MBS, whichever is less.

221 (f) Where a delay in the credentialing of a provider causes the service to be deemed
222 out-of-network, the insurer shall compensate the provider at the provider's full rate at no
223 expense to the patient.

224 33-20E-5.

225 (a) Notwithstanding any provision of law to the contrary, an insurer that provides any
226 benefits to covered persons with respect to emergency medical services shall pay for such
227 emergency medical services:

228 (1) Without the need for any prior authorization determination and without any
229 retrospective payment denial for services rendered; and

230 (2) Regardless of whether the health care provider furnishing emergency medical
231 services is a participating provider with respect to emergency medical services.

232 (b) In the event a covered person receives emergency medical services by a
233 nonparticipating provider or hospital, the nonparticipating provider or hospital shall bill the
234 insurer directly and the insurer shall directly pay the nonparticipating provider or hospital
235 as coded for the emergency medical services rendered to the covered person in accordance
236 with Code Section 33-24-59.14 the lesser of:

237 (1) The nonparticipating provider or hospital's actual billed charges; or

238 (2) In the case of a health care provider, the minimum benefit standard.

239 (c) A health benefit plan shall not deny benefits for emergency medical services previously
240 rendered, based upon a covered person's failure to provide subsequent notification in
241 accordance with plan provisions, where the covered person's medical condition prevented
242 timely notification.

243 (d) Insurers shall not communicate or include in written form false, misleading, or
244 confusing information in their explanation of benefits to patients or guarantors regarding
245 usual and customary costs, balance billing, or mediation disputes between physicians and
246 insurers.

247 (e) For purposes of the covered person's financial responsibilities, the health benefit plan
248 shall treat the health care services the covered person receives from a nonparticipating
249 provider pursuant to this Code section as if the services were provided by a participating
250 provider, including counting the covered person's cost sharing for such services toward the
251 covered person's deductible and maximum out-of-pocket limit applicable to services
252 obtained from participating providers under the health benefit plan.

253 33-20E-6.

254 No health benefit plan shall deny or restrict covered benefits from a participating provider
255 to a covered person solely because the covered person obtained treatment from a
256 nonparticipating provider. Notice of such protection shall be provided in writing to the
257 covered person by the insurer.

258 33-20E-7.

259 (a) A health benefit plan contract issued, amended, or renewed on or after July 1, 2020,
260 shall provide that if a covered person receives emergency medical services from a
261 nonparticipating provider, such covered person shall not be required to pay more than the
262 same amount that the covered person would have to pay for the same emergency medical
263 services received from a similar participating provider at a similar in-network facility.
264 Such amount shall be referred to as the 'in-network cost-sharing amount.'

265 (b) Neither a nonparticipating provider nor a participating provider shall bill or collect any
266 amount from the covered person for emergency medical services subject to subsection (a)
267 of this Code section other than the patient's coinsurance, copayments, and deductibles,
268 which is limited to the in-network cost-sharing amount.

269 33-20E-8.

270 (a) A violation of this chapter by an insurer shall be subject to penalties as determined by
271 the Commissioner.

272 (b) A violation of this chapter by a health care provider shall be subject to penalties as
273 determined by the applicable licensing board regulating such health care provider.
274 (c) A violation of this chapter by a hospital shall be subject to penalties as determined by
275 the Department of Community Health pursuant to its enforcement powers in Title 31.

276 33-20E-9.

277 (a) Where a patient obtains medical services, not including emergency medical services,
278 and an unexpected event arises resulting in a surprise bill to a patient, mediation shall be
279 available from the department where the resulting bill to the patient is greater than
280 \$1,000.00, provided that:

281 (1) Participants in such a mediation shall include the patient or the patient's authorized
282 representative, the insurer, and the provider of the care resulting in the bill to the patient;
283 (2) Patients shall submit accurate and complete health insurance information prior to
284 initiating mediation;
285 (3) Where possible, mediation shall occur by teleconference;
286 (4) In determining appropriate payment, the Gould Standard shall be taken into account
287 by the parties involved; and
288 (5) Costs not specific to any one party shall be shared evenly among all parties to the
289 mediation.

290 (b) The department shall develop rules in accordance with the requirements of this Code
291 section."

292 **SECTION 4.**

293 This Act shall become effective on July 1, 2019; provided, however, that Section 2 of this
294 Act shall become effective January 1, 2020.

295 **SECTION 5.**

296 All laws and parts of laws in conflict with this Act are repealed.